Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
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January 16, 2008

Via Electronic Mail and FedEx Delivery

David M. Hansen, Chairman of the Board
PACIFICARE OF CALIFORNIA
5995 Plaza Drive
Cypress, CA 90630

RE: FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF PACIFICARE OF CALIFORNIA

Dear Mr. Hansen:

Enclosed is the Final Report of the non-routine examination of PacifiCare of California (the "Plan"). The Department of Managed Health Care (the "Department") conducted the examination pursuant to Rule 1300.71.38 (m) (1) and Section 1382 (b) of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").[1] The Department issued an Interim Preliminary Report to the Plan on July 16, 2007 and a Preliminary Report on September 28, 2007. The Department accepted the Plan's response to the Interim Preliminary Report on August 30, 2007 and the Plan's response to the Preliminary Report on November 14, 2007. The Department also received monthly status reports for the months of September, October and November 2007 from the Plan on the progress of its corrective action plan.

This Final Report includes a description of the compliance efforts included in the Plan's August 30, 2007 and November 14, 2007 responses, along with information received in the monthly status reports from the Plan, in accordance with Section 1382 (c).

Section 1382 (d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended and provide electronically those portions of the Plan's response exclusive of

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append an addendum response or brief statement summarizing the Plan's August 30, 2007 and/or November 14, 2007 responses to the report or wishes to modify any information provided to the Department in its responses, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum or statement electronically via the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/ as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  1) File Type; select "Amendment to prior filing";
  2) Original Filing, select the Department's assigned "Filing No. 20071897" by clicking on the down arrow; and
  3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan addendum response to Final Report (FE5)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response. After upload, then select "Complete Amendment",
- Select a "Signatory,"
- Complete "Execution" and then click "complete filing".

As noted in the attached Final Report, the Plan's August 30, 2007 and November 14, 2007 responses did not fully resolve the deficiencies noted and the corrective actions required in the Preliminary Interim Report dated July 16, 2007 and the Preliminary Report dated September 28, 2007. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for the corrective action requested in the Final Report, within thirty (30) days after receipt of the report.

Please file the Plan's response to the Final Report electronically via the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  1) File Type; select "Amendment to prior filing";
  2) Original Filing, select the Department's assigned "Filing No. 20071897" by clicking on the down arrow; and
  3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: " Plan's Response to Final Report (FE10)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response. After upload, then select "Complete Amendment",

- Select a "Signatory,"
- Complete "Execution" and then click "complete filing".

Questions or problems related to the electronic transmission of the response should be directed to Siniva Pedro at (916) 322-5393 or email at spedro@dmhc.ca.gov. You may also email inquiries to wpso@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of the letter.

If you have any questions regarding this report, please contact me.

Sincerely,

JANET NOZAKI
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

ad/sm:jn

cc: Susan Berkel, Chief Financial Officer, PacifiCare of California
Mark Wright, Chief, Division of Financial Oversight
Marcy Gallagher, Chief, Division of Plan Survey
Linda Azzolina , Counsel, Division of Licensing
Susan Miller, Examiner, Division of Financial Oversight
Lorilee Ambrosini, Examiner, Division of Financial Oversight

CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF

PACIFICARE OF CALIFORNIA

FILE NO. 933 0126

DATE OF FINAL REPORT: JANUARY 16, 2008

SUPERVISING EXAMINER: JANET NOZAKI

EXAMINER-IN-CHARGE: AGNES DOUGHERTY

FINANCIAL EXAMINERS:

GALAL GADO
MARIA MARQUEZ
LISA MEDINA
SUSAN MILLER

BACKGROUND INFORMATION FOR PACIFICARE OF CALIFORNIA

Date Plan Licensed:	March 28, 1975
Organizational Structure:	PacifiCare of California, Inc. was incorporated as a nonprofit health maintenance organization in 1975 and converted to for-profit status in 1984. The Plan is a wholly owned subsidiary of PacifiCare Health Plan Administrators, Inc. ("PHPA"). PHPA is a wholly owned subsidiary of PacifiCare Health Systems, LLC, (Parent) formerly PacifiCare Heath Systems, Inc. Effective December 20, 2005, the Parent became a wholly owned subsidiary of UnitedHealth Group Incorporated.
Type of Plan:	The Plan is a full service plan and arranges for comprehensive health care services to its enrollees of commercial group subscribers, small group subscribers, point-of-service subscribers, and Medicare beneficiaries under the Medicare + Choice program through contracts with the Centers for Medicare & Medicaid Services.
Provider Network:	The Plan provides health care services by contracting with participating medical groups on a capitated basis, as well as direct contracts with individual physicians on a discounted fee-for-service basis. Hospitals are compensated on a capitated, per diem or case rate basis. Specialty care is arranged through the participating medical group network of contracted specialists.
Plan Enrollment:	1,587,566 enrollees as of September 30, 2007.
Service Area:	The service area consists of all major counties in California.
Date of Last Public Routine Financial Examination Report:	March 23, 2005

FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF PACIFICARE OF CALIFORNIA

This is the Final Report of the non-routine examination of PacifiCare of California (the "Plan"). The Department of Managed Health Care (the "Department") conducted the examination pursuant to Rule 1300.71.38 (m) (1) and Section 1382 (b) of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").[1] The Department issued an Interim Preliminary Report to the Plan on July 16, 2007 and a Preliminary Report on September 28, 2007. The Department accepted the Plan's response to the Interim Preliminary Report on August 30, 2007 and the Plan's response to the Preliminary Report on November 14, 2007. The Department also received monthly status reports for the months of September, October and November 2007 from the Plan on the progress of its corrective action plan.

On June 4, 2007, the Department commenced a non-routine examination of the Plan. The purpose of the examination was to verify corrective actions made by the Plan in response to the Department's Preliminary Report dated September 30, 2005 regarding the Plan's Provider Dispute Resolution Mechanism. The examination also reviewed the Plan's claims processing operations due to the disclosure of significant deficiencies during a site visit on February 7, 2007 by the Department, and the corrective actions represented to the Department resulting from the site visit. In addition, the Department has received numerous complaints from providers regarding the Plan's claims settlement practices.

On July 16, 2007, the Department issued a Preliminary Interim Report prior to the completion of the non-routine examination due to findings of substantial violations that required the Plan to immediately begin corrective actions to resolve the deficiencies. To resolve the issues disclosed in the Department's Preliminary Interim Report, the Plan filed a response on August 30, 2007 which documented its corrective actions.

This Final Report includes a description of the compliance efforts included in the Plan's August 30, 2007 and November 14, 2007 responses, along with information received in the monthly status reports from the Plan, in accordance with Section 1382 (c). The Plan's responses are noted in *italics*. Our findings are presented in the accompanying attachment as follows:

Section I. Compliance Issues
Section II. Non-routine Examination

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for the corrective action requested in this report, within 30 days after receipt of this report.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

SECTION I. COMPLIANCE ISSUES

A. CLAIM SETTLEMENT PRACTICES – "UNFAIR PAYMENT PATTERN"

Section 1371 requires that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 45 working day period. This Section also requires that all interest that has accrued shall be automatically paid. The penalty for failure to comply with this requirement shall be a fee of ten ($10) dollars.

Section 1371.35 (b), which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 45 working days after receipt, the plan shall pay the greater of $15.00 or interest at the rate of 15% per annum, beginning with the first calendar day after the 30 working day period. The penalty for failure to comply with this requirement shall be a fee of ten ($10) dollars.

Rule 1300.71 (a) (8) provides guidance for establishing that a Plan has engaged in an unfair payment pattern. It states that a "demonstrable and unjust payment pattern" or "unfair payment pattern" means any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

The Plan self-reported to the Department, substantial processing errors in connection with its Point-of-Service (POS), Out-of-Network (OON) claims and its failure to properly integrate processing of these claims between its two claim systems, NICE and RIMS. The Plan has acknowledged that errors with these processes were the cause of claim payment delays, incorrect denials, and incorrect payments. Rework projects to remediate incorrectly processed claims began in February, 2007. Claims requiring rework were selected by the Plan from claims that were processed from April 1, 2006 to April 30, 2007. The Plan stated that the total affected claims identified were approximately 79,000 claims. The Plan initially stated that these claims were reprocessed and remediated prior to the start of this examination on June 4, 2007.

The Department has determined that the numbers and types of deficiencies discovered in our examination demonstrate that the Plan's remediation effort was not adequate.

Our preliminary examination findings (reported in the Department's Preliminary Interim Report dated July 16, 2007) found that the Plan is engaged in a demonstrable and unjust payment pattern as follows:

1. Rule 1300.71 (a)(8)(F) states that one of these unjust payment patterns is the failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period.
   The Plan incorrectly denied claims to providers as follows:

- We reviewed fifty (50) denied claims, randomly selected from the claims system the Plan uses to process Point-of-service (POS) claims, called "RIMS". Twenty (20) of these claims, or 40%, were denied incorrectly. Examples of incorrect denials included:

Sample No.	Claim No.	Reason for Incorrect Denial
RIMS-B D-11	77094827-01	Incorrectly denied for no authorization, but no authorization was needed. An authorization number was included on the claim.
RIMS-B D-18	76088564-01	Incorrectly denied as non-participating provider, but the provider was participating (contracted).
RIMS-B D-26	76047887-01	Incorrectly denied as "not a covered benefit", but was a covered benefit.
RIMS-B D-30	77004048-01	Incorrectly denied for member exceeding maximum number of treatments, but the member had not reached the maximum.
RIMS-B D-37	76046803-01	Incorrectly denied for claim not filed within filing deadline, but received date of the claim was incorrect and therefore the claim was filed prior to the deadline.

- We reviewed twenty-five (25) denied claims, randomly selected from the claim system the Plan uses to process HMO claims, called "NICE". Twenty-three (23) of these claims were denied as IPA/Medical Group financial responsibility; and therefore, they were redirected by the Plan to the IPA/Medical Group for processing. Five (5) of these redirected claims, or 21.7%, were denied incorrectly because they were out-of-area claims that were actually the financial responsibility of the Plan, and not the financial liability of the IPA/Medical Group.

- Our analysis of Point-of-Service (POS) claims denied from January 1, 2006 through June 14, 2007, noted a total of 40,784 denied claims of which 22,707, or 55.68%, were denied as duplicate claim submissions. Out of these 22,707, we noted that 14,842, or 65.4%, were all denied in the month of April 2007. The Plan stated the reason for the high number of denials in the month of April 2007 was due to a reprocessing and remediation effort in connection with claim processing errors in their Point-of-Service claims system called "RIMS". To remediate the claim processing errors in the RIMS system, the Plan incorrectly denied claims that were previously paid. The Plan also incorrectly issued denial letters to the providers stating that the providers had submitted duplicate claims when they had not.

  The Plan provided information that linked twenty-six of these denials included in our sample to a previously paid claim to demonstrate that although it had issued denial letters incorrectly, the denials could all be linked to a prior payment. However, this sample is not representative of the population of claims denied as duplicates. The Plan acknowledged that it should have internally denied the claims and avoided the issuance

of incorrect denial letters to providers. In addition, six (6) denials, or 23%, had been processed incorrectly before the denial was issued because interest owed on the claim was not automatically paid prior to the denial and was not paid until after the Department selected them for further review.

2. Rule 1300.71 (a)(8)(K) states that one of these unjust payment patterns is the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

   The Plan failed to reimburse complete claims with the correct payment including the automatic payment of all interest as follows:

   - We reviewed twenty-five (25) late paid claims from the HMO claims system, NICE. Four (4) of these claims, or 16%, did not pay interest correctly on the late payment as required by Sections 1371 and 1371.35. We noted that the reasons for the late payments were due to incorrect processing of the claim when it was initially received. Upon subsequent reprocessing, interest on the late adjustments were not paid and therefore, interest and the $10 fee were owed on the following:

Sample No.	Claim No.	Days Late[1]	Reason for Late Payment
NICE LP-3	3362499210100092	209	Initially processed incorrectly as non-contracted provider claim. Upon reprocessing, failed to automatically pay interest.
NICE LP-4	3317463250300011	87	Initially processed using incorrect CMS fee schedule. Upon reprocessing, failed to automatically pay interest.
NICE LP-6	3345022510100007	151	Plan did not pay the greater of $15 or 15% for this emergency claim in accordance with Section 1371.35.
NICE LP-7	3364930750300036	74	Initially processed claim using incorrect CMS fee schedule. Upon reprocessing, failed to automatically pay interest.

   - We reviewed twenty-five (25) late paid claims from the Point-of-Service claims system, RIMS. Late payments on a substantial number of these claims resulted from the failure to properly transition Point-of-Service Out-of-Network claims from the Plan's NICE system to its RIMS system. The failure to process these claims was realized during the

[1] The Department is using the 64 calendar day standard adopted by ICE to calculate 45 working days.

reprocessing and remediation effort that began in February 2007. Seventeen (17) of the twenty-five (25) late claims reviewed, or 68%, had substantial delays because claims information failed to be manually "re-keyed" to the RIMS system for adjudication after initially being processed in the NICE system. The average number of days to transition from NICE to RIMS for these seventeen claims was 126 days. Although, the Plan paid interest and the $10 fee on these claims during its reprocessing and remediation effort, the interest amount was not correctly calculated for all of these claims. Three (3) late claims in our sample of 25, or 12%, were underpaid interest as follows:

Sample No.	**Claim No.**	**Days Late**[2]
RIMS-B LP-1	127702826501	84
RIMS-B LP-7	127705742501	76
RIMS-B LP-19	127700212001	143

The Department's Preliminary Interim Report required the Plan to immediately begin corrective actions to resolve the deficiencies cited above. In addition, the Plan was required to submit a monthly status report on its corrective actions. The monthly status report was to include a description of any new problem found by the Plan, a description of the root cause of the problem, and the action(s) taken by the Plan to correct the problem. The Plan was required to provide a copy of its revised policy and procedures with its response. Furthermore, the Plan was required to state the date of implementation, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

The Plan's August 30, 2007 response is summarized below:

The Plan acknowledged that twenty (20) POS claims were inappropriately denied. The Plan's corrective actions included:

Adjudication of POS Claims

1. Centralizing all POS claims processing in Cypress, California.

The Plan stated that it began the transition of POS claims processing to Cypress, California on July 9, 2007. They stated that the transition plan will be completed by December 31, 2007, including POS claims reprocessing.

The Plan also provided the following Table to show the revised process compared to the process in place during the Department's examination.

[2]By email dated June 13, 2007, the Plan was notified that the Department's current position is that a full service plan that offers a Knox-Keene POS product is to comply with the 45 working day requirement of Section 1371 and Rule 1300. 71(g). Previously, the Department required a full service plan to comply with the 30 working day requirement of Rule 1300.71 (f) (1).

	Newly Revised Process	***Old Process***
Location of Staff Processing In-network Claims	*Cypress, California*	*Letterkenney, Ireland*
Location of Staff Processing Out-of-network Claims	*Cypress, California*	*MedPlans Partners, Inc (claims processing vendor)*
Identification of out of network claims for processing.	*Cypress, California*	*Letterkenney, Ireland*
Entry of out of network claims for processing.	*San Antonio, Texas*	*Lason (scanning and data entry vendor)*
Information System Used for In-network Claims	*NICE*	*NICE*
Information System Used for Out-of-network Claims	*RIMS*	*RIMS*

Based on the implementation of the above changes, the Plan stated that it expects to improve its POS claims processing turn around times. The POS turn around times will be based on a 45 working day calculation, consistent with HMO and as discussed with the Department. The Plan stated that it expects to be in compliance with AB1455 claims processing for the fourth quarter of 2007; but for the POS calculations, the Plan stated that claims paid and denied within 45 working days will improve from 75% at October 2007 to 95% at December 2007.

2. Retraining all POS claims examiners by August 31, 2007.

The Plan stated that all Cypress POS claims examiners attended training on August 22, 2007. The session included specific training around the audit findings, including how to:

- *confirm if an authorization is required, and if it is, how to match to that authorization,*
- *confirm that the correct provider contract has been selected,*
- *confirm if the service is a covered benefit, and*
- *confirm the number of treatments allowed and if services to date are within the limit.*

3. Enhancing POS reporting by November 1, 2007.

The Plan stated that to ensure that all claims denied in NICE for out of network claims adjudication are appropriately entered into RIMS, the Plan will implement daily reporting that compares the number of NICE POS claims denials to those entered into RIMS. The Plan will also implement a cumulative error report that lists those POS claims denied in NICE that were not subsequently entered into RIMS. The Plan will implement these reports by November 1, 2007 and will include a sample report in the monthly reporting to the Department by December 1, 2007. In addition, the Plan will continue its weekly reporting of POS claims turn around times and processing volumes and will also include those results in the monthly reporting to the Department by November 1, 2007.

4. Implementing self-audits of POS denied claims by October 1, 2007 to confirm that errors are being mitigated.

To ensure improved performance of POS claim denials, the Plan stated that it will conduct a weekly self-audit of fifty (50) POS denied claims to confirm that each denial was appropriate. The weekly self-audit will begin by October 1, 2007 and will end December 31, 2007, if the Plan determines that weekly self-audits are no longer necessary.

The self-audit will be conducted by internal staff dedicated to quality oversight of operations. This team is independent of the POS claims processing team and reports to a different management team within UnitedHealthcare. The Plan believes it is appropriate to engage this team for this purpose, as it represents a separation of duties and management that will contribute to the objectivity of the self-auditing process. The audit results will be reported to the POS claims team on an ongoing basis and the Plan's Vice President of Transactions Oversight will review the audit results on a monthly basis. These audit results will be included in the monthly reporting to the Department by December1, 2007.

5. POS Rework Project And Associated Inappropriate Denials.

The Plan acknowledged that approximately 23,000 POS out-of-network claims were inappropriately reprocessed, then denied as duplicates, and denial letters issued, when the claims had been previously paid. The Plan believes that the inappropriate duplicate denials were caused by the unique circumstances of the POS reprocessing project and will not be a recurring issue.

In February 2007, the Plan self-reported to the Department that not all POS claims had been paid correctly. The Plan had not appropriately transferred out-of-network POS claims to San Antonio for processing on RIMS. To ensure that all impacted claims were identified for reprocessing, certain claims were entered into RIMS that had been previously paid. Therefore, when the claim was reprocessed in RIMS, the claim was identified as a duplicate and a denial explanation of payment (EOP) for duplicate claim was issued. The Plan acknowledged that the provider did not submit a duplicate claim and that a denial EOP should not have been sent. The Plan had previously paid all claims and these should not have been reprocessed.

As of July 26, 2007, the Plan stated that it had implemented a corrective action that causes a POS claim that is inappropriately entered into RIMS a second time to be denied as a "no pay" claim. The Plan stated that the "no pay" denial will not generate an EOP. A claim is considered to have been inappropriately entered into RIMS if it was paid based on the initial claim submission and the provider has not resubmitted the claim.

Adjudication of HMO Claims

The plan acknowledged that five HMO claims were inappropriately denied as IPA/medical group financial responsibility when they were actually out of area claims that were the financial

responsibility of the Plan. The Plan's corrective actions included:

1. *Correction to out of area determination function.*

   On May 31, 2007, the Plan implemented a correction to the out of area mileage determination function within its NICE claims processing system. Prior to that fix, the system was not consistently performing the appropriate mileage calculation which contributed to certain claims being deemed "in-area" when they were actually for services received "out of area," and therefore the Plan's payment responsibility.

2. *Reporting on Claims returned to capitated IPA/medical groups.*

   The Plan stated that it will produce weekly specific provider-level trend reporting on paid claims that were initially determined to be the financial liability of the IPA/medical group. As necessary, the Plan will implement an action plan for those providers that show an unusual amount of group return activity. The Plan will research the root cause behind such fluctuation and will take steps to resolve issues timely, including reviewing contract language and terms, if necessary. The Plan stated that it's Vice President of Transactions Oversight will review the trend reports on a monthly basis and the results will be included in the monthly reporting to the Department as of November 1, 2007.

Calculation of Interest and Penalties

1. *Corrective Action for RIMS Interest.*

   The Plan acknowledged that six of 26 sampled POS out-of-network claims payments did not include the required interest. Claims examiners relied on RIMS to systematically calculate and pay the interest. The interest did not systematically calculate by RIMS because the claim was manually entered directly into RIMS. The Plan stated that manual entry, instead of batch processing, bypasses the programming that pays interest on late claims. The practice of manually entering a claim directly into RIMS should occur on an exception basis and only for certain escalated issues. In addition, the following corrective actions were taken:

   - *The Plan issued a training bulletin on August 28, 2007 to emphasize that claims are to be entered into RIMS directly on an exception only basis. A separate training bulletin was issued on August 14, 2007 that included the details of the correct manual calculation of interest. Copies of these training bulletins are included with the Plan's response.*

   - *The Plan will implement focused audit procedures related to accurate interest payments on those claims that are entered manually into RIMS. These self-audits will begin by October 1, 2007 and will end December 31, 2007, unless the Plan determines that continued auditing is necessary. Self-audits will be conducted by internal staff dedicated to quality oversight of operations. This team is independent of the POS claims*

processing team and reports to a different management team within UnitedHealthcare. The Plan believes it is appropriate to engage this team for this purpose, as it represents a separation of duties and management that will assure the objectivity of the self-auditing process. The Plan's Vice President of Transactions Oversight will review the results on a monthly basis. The results will be included in the monthly reporting to the Department by December 1, 2007.

2. *Corrective Action for HMO Late Paid Claims and Interest & Penalty.*

The Plan agreed that 4 of the 25 HMO late paid claims did not pay interest correctly. The following corrective actions were taken:

- *The Plan stated that it had updated its Interest Application Policy and Procedure on July 25, 2007 to specifically address the emergency room interest rate calculation. The Plan provided updated training on this topic to the claims processing staff via team meetings. The Manager of HMO Claims Processing issued an updated policy update. A copy of this updated policy was included with the Plan's response.*

- *The Plan stated that it would implement weekly self-audit procedures of late HMO claims payments to ensure that interest and penalties are being calculated correctly. The Plan stated that self-audits will begin by October 1, 2007 and will end December 31, 2007, unless the Plan determines that continued auditing is necessary. The Plan stated that self-audits will be conducted by internal staff dedicated to quality oversight of operations. This team is independent of the HMO claims processing team and reports to a different management team within UnitedHealthcare. The Plan believes it is appropriate to engage this team for this purpose, as it represents a separation of duties and management that will assure the objectivity of the self-auditing process. The Plan's Vice President of Transactions Oversight will review the results on a monthly basis. The results will be included in the monthly reporting to the Department as of December 1, 2007.*

- *The Plan's Vice President of Transactions Oversight will also review fee schedule update reports on a monthly basis to confirm that CMS fee schedules are updated timely upon receipt from CMS. The results will be included in the monthly reporting to the Department by December 1, 2007.*

As previously stated, the Plan has updated the number of calendar days in its RIMS programming as of August 25, 2007 to align with the Department's final interpretation of converting the legally required 45 working days into 64 calendar days. This will mitigate the overpayment of interest on future claim payments.

In summary, the Plan stated that all corrective actions described in Section A, except where noted, are being overseen by the Vice President of Transactions Oversight located in Cypress, California. The Plan stated that it will submit a monthly status report for the month ended

September 30, 2007 to the Department beginning November 1, 2007. The report will include progress on items included in the response above and other items necessary to demonstrate the Plan's progress. The Plan will also provide information related to ongoing self-audit results, including root cause remediation.

The Plan's September 6, 2007 response stated that it disagreed with the Department's findings that three (3) of the twenty-five (25) RIMS late paid claims underpaid interest. The Plan stated that three (3) claims were initially considered underpaid by the Department because its testing used 60 calendar days in the calculation instead of the standard 64 calendar days. The Plan subsequently paid the additional interest as calculated and requested by the Department. This conclusion was incorrect because the Department did not use 60 calendar days in the calculation.

The Plan requested the Department to cease further examination of denied claims in accordance with the Department's statistical sampling procedures in exchange for an Acknowledgement, executed by the Plan on August 10, 2007, that the issues the Department identified in its operations and claims payment systems were found to violate the Knox-Keene Act and Rule 1300.71 (a)(8) (F).

The Plan also requested the Department to cease further examination of late claims in exchange for an Acknowledgement, executed by the Plan on August 10, 2007, that the issues the Department identified in its operations and claims payment systems were found to violate the Knox-Keene Act and Rule 1300.71 (a)(8) (K).

The following are additional claim findings not reported in the Preliminary Interim Report:

- The Department reviewed a total of one hundred (100) denied claims, randomly selected from the claims system the Plan uses to process Point-of-service (POS) claims, called "RIMS". Thirty-nine (39) of these claims, or 39%, were denied incorrectly. The Department's Preliminary Interim Report reported similar findings after review of the first fifty (50) of these denied claim sample of one hundred (100) denied claims. The findings for the remaining sample were the same.

- On July 18, 2007, subsequent to the issuance of the Preliminary Interim Report, the Plan notified the Department that the denied file extract for NICE claims provided to the DMHC on June 4, 2007, was incomplete. A new data extract was provided and a replacement 50 NICE denied claims were selected and review. The findings of this review were similar to the findings reported in the Preliminary Interim Report because ten (15) of fifty (50) or 30% were denied incorrectly. The majority of incorrect denials were because the Plan believed the claims to be the responsibility of the IPA/Medical Group when they were actually the Plan's responsibility.

All of the above violations were referred to the Office of Enforcement for administrative action.

The Department reviewed the Plan's August 30, 2007 response to the Interim Preliminary Report and the Corrective Action Plan (CAP) included in the response. The Department noted that the CAP included weekly self-audits of POS denied claims to confirm that each denial was appropriate. The Plan stated that weekly self-audits are to begin by October 1, 2007 and end December 31, 2007, if the Plan determines that weekly self-audits are no longer necessary. This corrective action does not provide sufficient detail about the methods used to determine if a denial is appropriate, the type of reporting that will be issued to document results of the audit, minimum and maximum number of errors to be used for determining acceptable levels and the measurements used to determine if the audits will continue or will be discontinued completely.

The Plan stated that for claims incorrectly returned to IPA/Medical Groups it will implement an action plan for those providers that show an unusual amount of group return activity. The Plan stated that it will research the root cause behind such fluctuation and will take steps to resolve issues timely, including reviewing contract language and terms, if necessary. This corrective action appears to focus on those providers that have high levels of group returns. It does not address incorrect group return activity for incorrect reasons and for groups who do not have high levels of returns. It also fails to include a review process by the Plan to ensure that these claims are forwarded to and paid by the IPA/Medical group after redirection. Our reviews found that several of the providers did not receive the redirected claim and this was not disclosed until after we requested the post-redirection review.

The Plan also stated that to ensure the correct payment of interest and penalties on late POS and HMO claims, it will implement weekly self-audit procedures of late HMO and POS claim payments to ensure that interest and penalties are being calculated correctly. The Plan stated that self-audits will begin by October 1, 2007 and will end December 31, 2007, unless the Plan determines that continued auditing is necessary. This corrective action does not provide sufficient detail about the type of reporting that will be issued to adequately document results of the audit, minimum and maximum number of errors to be used for determining acceptable levels and the measurements used to determine if the audits will continue on a limited basis or will be discontinued completely.

<u>The Plan was required to revise its CAP to address the issues above and to complete the following additional corrective actions:</u>

The Plan was required to review all late paid claims and all late adjustments resulting from provider disputes, during the period December 1, 2005 through the date of the Plan's response to this report, to determine whether interest was paid correctly in accordance with Rule 1300.71 (a)(8)(K), Sections1371 and 1371.35.

For those late payments where interest was not paid or underpaid, the Plan was required to submit a detailed CAP to bring the Plan into compliance with the above requirements that should include, but not be limited to, the following:

a. Identification of those claims and provider disputes requiring remediation.

b. Evidence that interest and $10 fee, as appropriate, were paid retroactively for the claims identified in paragraph "a" above. This evidence was to include an electronic data file/schedule (ACCESS) that identifies the following:

- Claim number
- Date original claim received
- Date new information received (date claim was complete)
- Total billed
- Original total paid
- Original paid date
- Amount of adjustment paid (w/ check number)
- Date adjustment paid
- Amount of original interest paid
- Original interest paid date
- Amount of additional interest paid (w/ formula)
- Number of Days Late Used to Calculate Interest (w/ formula)
- Date additional interest paid
- $10 fee paid
- Date $10 fee paid
- Check number for interest and/or penalty
- Provider name
- ER or Non-ER indicator

The data file was to provide the detail of all claims remediated; and, to include the total number of claims and the total additional interest and $10 fee paid, as a result of remediation.

If the Plan was unable to complete remediation by the due date of the response to this report, the Plan was required to submit a timeline that is no longer than one year from the due date which reflects progress and completion of the remediation. In addition, the Plan shall submit monthly status reports to the Department until the remediation is completed.

The Plan's November 14, 2007 response is summarized below:

The Plan responded that its weekly self audits of POS denials are performed based upon a random sample of fifty denied POS claims. They are evaluated against the Plan's standard claims processing policies and procedures to determine whether a denial was appropriate. The audit procedures include, but are not limited to, confirming use of the correct receipt date when a claim is denied for timely filing, confirming use of the correct schedule of benefits when a claim is denied for "not a covered benefit" and confirming the necessity of an authorization when a claim is denied for "no authorization". The Plan's self-audits are evaluated against the Claims Payment Accuracy (CPA) measurement. This performance measure is defined as the "percent of claims without financial errors." The Plan's success standard for the CPA

measurement is 97%. Therefore, if the Plan achieves a success rate of 97% or higher for the cumulative audit results for the period October 1, 2007 to December 31, 2007, the Plan will no longer deem it necessary for the focused audits to continue. However, POS denials will continue to be included in the Plan's standard monthly quality audits. In its monthly reporting, the Plan has developed comprehensive reporting of its self-audit results which include the audit results, the details of the sample and any corrective actions taken, if applicable.

The Plan's ongoing or planned corrective actions included the following:

- *Re-adjudicating claims processed incorrectly from February 9, 2007 to May 31, 2007 because the out of area determination programming was inaccurate. Remediation timing will be determined by December 14, 2007.*
- *Implementing a process to capture and identify root cause on all paid claims that were initially determined to be the financial liability of the IPA/medical group by February 1, 2008.*
- *Hiring six additional staff to research root cause issues, address provider specific issues and re-directed claim procedures and implement related process changes/corrective actions by February 1, 2008. The recruiting process has begun for these additional positions.*

The Plan responded that its weekly self-audits of the correct payment of interest and penalties on late HMO and POS claims are performed based upon a random sample of fifty late paid POS claims and fifty late paid HMO claims. They are evaluated against the Plan's standard claims processing policies and procedures to determine whether the interest and penalty were applied appropriately. The Plan's self-audits are evaluated against the Claims Payment Accuracy (CPA) measurement. This performance measure is defined as the "percent of claims without financial errors." The Plan's success standard for the CPA measurement is 97.00%. Therefore, if the Plan achieves a success rate of 97.00% or higher for the cumulative audit results for the period October 1, 2007 to December 31, 2007, the Plan will no longer deem it necessary for the focused audits to continue. However, the application of HMO and POS interest and penalty on late paid claims will continue to be included in the Plan's standard monthly quality audits.

The Plan also has developed comprehensive reporting of the self-audit results which include the audit results, the details of the sample and any corrective actions taken, if applicable.

The Plan stated it will review all late paid claims and all late adjustments during the period December 1, 2005 through November 14, 2007 to determine whether interest was paid appropriately. The Plan is in the process of performing a quality review of the report detailing the claims to be reviewed for possible remediation to ensure its accuracy. The Plan estimates completion of the quality review by December 14, 2007. After the quality review is complete, the Plan will determine the remediation timing and will provide updates to that work plan in the monthly reporting to the Department. The Plan will provide all evidence as noted above.

The Department finds that the Plan's compliance efforts are not fully responsive to the deficiencies cited and corrective actions required. The Plan's response did not include an action plan to address incorrect group return activity for incorrect reasons and for groups who do not have high levels of returns. It also failed to include a review process by the Plan to ensure that these claims are forwarded to and paid by the IPA/Medical group after redirection. The Plan is required to submit an action plan to address these two issues.

The Plan is required to maintain an ongoing monitoring process of the separate payment areas and systems to timely determine root causes of inappropriate interest payment before they become systemic. In addition, the Plan is required to continue its monitoring process for a sufficient length of time (i.e. additional six months) after compliance levels are achieved to demonstrate ongoing compliance.

In its November 2007 monthly status report to the Department, the Plan reported that a Vice President of Transactions Oversight was hired. Due to the significant responsibilities that this individual will hold, the Plan is required to submit the qualification and experience of the individual hired with its response to this report.

The Department acknowledges that the Plan anticipates that its remediation efforts will be completed by August 2008 as reported in its November 2007 status report. In addition, the Department acknowledges that 95% compliance may not be achieved by the Plan until remediation is complete because of the remediation's impact on the compliance percentage. However, the Plan is required to submit evidence of its remediation efforts on a monthly basis. These monthly status reports are due within 15 days following the close of each month. The first status report will be due on February 15, 2008, listing individually by claim all interest and penalties paid up to January 31, 2008. The status report should be submitted through the Department's eFiling web portal, as described in the cover letter, until the remediation is fully completed. Large remediation files can be submitted directly to the Department on a CD with an E-1 filing submitted through the web portal stating that the remediation file was submitted directly to the Department on a CD.

B. PROVIDER DISPUTE RESOLUTION

Rule 1300.71.38 states that all health care service plans and their capitated providers that pay claims (plan's capitated provider) shall establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. This rule further states that each mechanism complies with sections 1367 (h), 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28.

Rule 1300.71.38 (f) requires the Plan to resolve each provider dispute or amended provider dispute, consistent with applicable state and federal law and the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.37, 1371.4 and 1371.8 of the Health and Safety Code and section 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of title 28, and issue a written

determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute. Our preliminary examination findings (reported in the Department's July 17, 2007 Preliminary Interim Report) found that the Plan failed to process provider disputes accurately and/or within the timeframes required.

As of July 17, 2007, we had completed a review of twenty-three (23) provider disputes. Five (5) of these or 21.7% were processed late because they were not resolved within forty-five (45) working days. Six (6) of these or 26% were processed incorrectly because the Plan did not resolve the dispute correctly.

The following examples were provided:

PDR No.	Claim No.	Incorrect determination and/or Late Resolution
NICE - PDR-1	2232334-03-007	Although claim was received with medical records including discharge summary, trauma run, trauma history and physical, final radiologic test results - trauma, ER physician orders, trauma flow sheet, interdisciplinary notes, and daily order summary in accordance with provider agreement, the claim was not paid at trauma rates. The Plan issued incorrect determinations. Provider submitted three disputes as a result of incorrect determinations.
NICE - PDR-3	2374572-03-008	Claim was contested for missing medical records although letter issued by Plan did not specify medical records required to process claim at trauma level of care. Multiple disputes were received. Second dispute received on 10/17/06 had the required medical records but was not resolved/ paid correctly nor timely.
NICE - PDR-10	7033050-01-014	Dispute was received with medical records on 9/26/06 as a result of a previous denial for no medical records. Incorrect determination because claim was denied as a duplicate and medical records were requested again on 11/2/06 and again on 12/6/06.
NICE - PDR-14	6558037-02-002	Dispute was received multiple times. Incorrect determinations resulted from documents related to the claim held in "Document DNA" queues that were not processed timely and late determinations/late payments resulted.
NICE - PDR-17	4740486-01-014	Dispute was not resolved timely. Payment of interest and penalties on the late payment was not made until 486 days from date of payment.

These preliminary findings demonstrate that the Plan issued incorrect determinations, requested medical records when they were not needed, or did not request records when they were needed to process the claim correctly. The Plan was also not in compliance with the dispute resolution turnaround times.

The Department's Preliminary Interim Report required the Plan to immediately begin corrective actions to resolve the deficiencies cited above. In addition, the Plan was required to submit monthly status reports on its corrective actions. The monthly status reports were to include a description of any

new problem found by the Plan, a description of the root cause of the problem, and the action(s) taken by the Plan to correct the problem. The Plan was required to provide a copy of its revised policy and procedures with its response. Furthermore, the Plan was required to state the date of implementation, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

The Plan's August 30, 2007 response is summarized below:

The Plan acknowledged the Department's findings. The Plan's ongoing or planned corrective actions included:

1. *A complete review of the Provider Dispute Resolution (PDR) process. The work plan for this review was submitted with the Plan's response.*

2. *PDR will be monitored by the Vice President of Transactions Oversight, a new position based in Cypress, California that reports to the Plan President.*

3. *A monthly status report on the Plan's PDR corrective actions will be submitted to the Department beginning November 1, 2007. The monthly report will include any new problems identified, the root causes and the corrective action plans.*

The Plan stated that from July 16, 2007 to date, in addition to review meetings supporting the items noted above, the Plan has:

- *Identified the need for additional staffing. The Plan is recruiting ten positions for the Cypress, CA based PDR team.*

- *Identified the need for additional staffing to perform functions to address member and physician inquiries and problem resolution.*

- *Begun flowcharting PDR intake sources and data flows.*

The Plan requested the Department to cease further examination of provider disputes in accordance with the Department's statistical sampling procedures in exchange for an Acknowledgement, executed by the Plan on August 10, 2007, that the issues the Department identified in its provider dispute resolution procedures, operations, tracking system (called REVA) and related finalization processes in its NICE and RIMS claim systems were found to violate Rule 1300.71.38.

The following are additional provider disputes findings not reported in the Preliminary Interim Report but reported in the Preliminary Report:

- The Department reviewed forty-nine (49) overturned provider disputes in total. Fourteen (14) or 29% were resolved incorrectly for reasons that were similar to the ones reported

in the interim preliminary report based upon a review of the first twenty-three (23) in our sample of forty-nine (49).

- Fourteen (14) or 29% of the forty-nine (49) overturned provider disputes reviewed were late because they were not processed within forty-five (45) working days as required by Rule 1300.71.38 (f).

- Eleven (11) or 22% of the forty-nine (49) overturned provider disputes reviewed had letters sent to the provider requesting information that was not needed to process the claim or requested the wrong information.

- Six (6) or 30% of twenty (20) upheld provider disputes reviewed had incorrect determination letters or inaccurate determination letters.

- Our review disclosed that incorrect determinations and incorrect determination letters often resulted because there was no process for ensuring that after review of the PDR by a PDR researcher, results of the review documented in the REVA system were interpreted correctly by the claim processor who was responsible for finalizing the claim and issuing the PDR determinations.

- Our review also disclosed that when a provider called about a claim dispute that the provider filed with the Plan, the Customer Service unit who received the call was not able to transfer the call to anyone in the claims processing unit or the provider dispute unit so that the provider dispute and claim history can be accessed by someone who can assist the provider with the dispute. The Customer Service unit merely instructs the provider to submit another dispute. We noted that many of the provider disputes review had multiple disputes associated with their claim dispute.

- The Plan also acknowledged that the Plan's PDR tracking system called REVA included claim projects submitted by providers at the Plan's request and/or initiated by the Provider. These "projects" included provider disputes and also first-time claim submissions. The Plan was not able to distinguish between first-time submissions and those claims submitted as a dispute. As a result, the Plan was not able to capture accurate PDR statistics for reporting to the Department in accordance with the requirements of Rule 1300.71.38 (k) "Annual Plan Claims Payment and Dispute Resolution Mechanism Report."

All of the above violations were referred to the Office of Enforcement for administrative action.

The Plan was required to submit a CAP that includes revisions to its operations and policies and procedures that will include but are not limited to the additional provider dispute findings noted above, and that will ensure provider disputes are processed accurately and timely in accordance with the requirements of Rule 1300.71.38.

The Plan's November 14, 2007 response is summarized below:

The Plan acknowledged the Department's findings and stated that the Plan's ongoing or planned corrective actions included the following:

- *The work plan for a complete review of the provider dispute resolution process was included in the Plan's response dated August 30, 2007, and status updates are included in the Plan's monthly reporting to the Department. This comprehensive review will address the Department's findings related to inappropriate dispute resolutions and the related letters. In addition, the Plan's review will address the Department's findings related to the late processing of provider disputes and the inability of customer service to appropriately access dispute information.*

- *The Plan will implement focused audit procedures related to the provider dispute resolution process including inappropriate dispute resolutions. The audit will also address the findings of incorrect information requests to the provider and incorrect interpretation of the dispute review by the claims examiners. The Plan's weekly self-audits of the provider dispute resolution process are performed based upon a random sample of fifty closed PDR cases. They are evaluated against the Plan's standard claims processing policies and procedures to determine whether the dispute was resolved appropriately.*

The Plan's self-audits are evaluated against the Determination Accuracy (DA) measurement. This performance measure is defined as the "percent of disputes resolved appropriately." The Plan's success standard for the DA measurement is 97.00%. Therefore, if the Plan achieves a success rate of 97.00% or higher for the cumulative audit results for the period December 1, 2007 to March 31, 2008, the Plan will no longer deem it necessary for the focused audits to continue. However, the proper determination of provider disputes will continue to be included in the Plan's standard monthly quality audits. The self-audit will be conducted by internal staff dedicated to quality oversight of operations. This team is independent of the PDR team and reports to a different management team within UnitedHealthcare. The Plan believes it is appropriate to engage this team for this purpose, as it represents a separation of duties and management that will assure the objectivity of the self-auditing process. The Plan's Vice President of Transactions Oversight will review the results on a monthly basis. The results will be included in the monthly reporting to the Department by February 1, 2008.

By January 1, 2008, the Plan stated that it will establish a dedicated rework team in Letterkenny, Ireland to adjudicate the dispute resolutions determined by the Cypress, California provider dispute research team. This dedicated team will help ensure consistent communication between the Cypress, California PDR researcher and the claims examiner to facilitate appropriate determinations. By February 1, 2008, the Plan stated that it will implement new processes to appropriately identify first time claim submissions so that they can be appropriately excluded from the Plan's PDR reporting.

The Department finds that the Plan's compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required. The Plan is required to submit the policy and procedure that will be used by the new rework team in Letterkenny with its response to this Final Report. In addition, the Plan needs to identify the management position responsible for overseeing the work of the new rework team and provide a description of the monitoring system implemented to ensure ongoing compliance by the team. Finally, the Plan is required to continue its monitoring process for a sufficient length of time (i.e. additional six months) after compliance levels are achieved to demonstrate ongoing compliance.

C. ADMINISTRATIVE CAPACITY

Section 1367 (g) and Rule 1300.67.3 require that health care service plans maintain "the organizational and administrative capacity to provide services to subscribers and enrollees" and that a plan's organization, administrative services, and policies must "result in the effective conduct of the plan's business" and "provide effective controls."

Our preliminary examination findings (reported in the Department's July 17, 2007 Preliminary Interim Report) found that the Plan had not demonstrated that it has maintained the organizational and administrative capacity to provide services to subscribers and enrollees as follows:

1. The Plan had not demonstrated "effective controls" to oversee the claims processing functions[3] that it delegated to the following affiliated[4] and non-affiliated entities:

Entity/Location	Contracting Party	Date Implemented	Claim Functions
Lason Systems, Inc. /Utah	PHS	May 2006	Front end – Scanning and maintenance of scanned records.
PacifiCare International Limited (PIL) /Ireland	Plan	1999	Claim Processing – Adjudication for NICE (HMO & In-network POS) including: • HMO stop loss claims • HMO chemo & injectible claims HMO rework claims
PSO (TX) PSO merged with PHPA. PSO is sometimes used in reference to the Texas location for	PHPA	May 2006	Claims Processing and Customer Service • HMO transplant claim processing • HMO Recovery

[3] This information was provided in this requested format to the DMHC examiners on June 26, 2007.
[4] PHS is PacifiCare Health Systems, LLC (Grandparent company). PHPA is PacifiCare Health Plan Administrators (Parent company)

Entity/Location	Contracting Party	Date Implemented	Claim Functions
PHPA.			• POS Out-of-Network
MedPlans Partners, Inc	PHS	May 2006	Claims Processing for POS Out-of-Network

All of the substantial deficiencies disclosed during the early stages of our examination and described in this report show that the Plan's processes are insufficient to provide effective controls over the claim operations.

The Plan provided information regarding the oversight and monitoring it performs over these delegated processes but the Department found that this was not sufficient given all the claim processing problems disclosed in this examination.

2. The Plan had not demonstrated that it had sufficient staffing and resources to manage its claims inventory. The Plan stated that the backlog in the Plan's Point-of-Service claims inventory grew because staff and resources were redirected to address contract loading problems affecting their PPO (preferred provider organization) line of business under the PacifiCare Life Insurance Company (Department of Insurance licensee). This demonstrated the Plan's failure to address compliance problems as needed because of its inability to allocate resources and staffing to ensure compliance with the claim settlement requirements.

3. The Plan failed to demonstrate that it can readily provide accurate contracts and contract information in order for the Department to review the payment accuracy of claims selected for our review. Thirteen (13) out of twenty-five (25) contracts or fee schedules were not provided timely and four (4) of these contracts could not be provided for the "RIMS-B Paid Sample" of claims selected for review for payment accuracy.

   In addition, it was brought to the Department's attention through numerous complaints from providers that the Plan had failed to properly "load" provider contracts causing claims to be incorrectly paid. At the start of the examination, the Plan informed the Department that this problem did not affect lines of business under PacifiCare of California. However, later in the examination this assertion was retracted and the Plan informed the Department that this problem did impact the PPO network which is utilized in the Plan's Point-of Service product Tier 2 option.

4. The Plan failed to demonstrate that it maintained adequate control over documents needed to process claims and provider disputes. These documents and other correspondence were delayed in queues and were not processed timely. These delays negatively impacted the Plan's ability to pay its claims correctly and to meet claims processing turnaround time requirements. The correspondence in connection with claims and provider disputes such as medical records and letters of agreement were not reviewed timely and were held in queues within the correspondence tracking system called "Document DNA."

It is apparent that under the current organizational structure, it is impossible for the Plan to demonstrate that it is able to exercise independent control over its operations, provide adequate oversight of delegated functions, and to have adequate resources (including staffing) to properly perform its claim processing functions to ensure compliance with the Knox-Keene Act and Regulations.

The Plan was required to file an undertaking that all executive management (i.e., CEO, CFO, COO and Medical Director) and key staff (i.e., Director of Regulatory Compliance, Claims, Information Technology and clinical staff) are to be employed by the Plan and located at the Plan's administrative offices in California, unless the Plan can show to the satisfaction of the Department through a Corrective Action Plan (CAP), that adequate oversight, authority and responsibility are retained by the Plan. If the CAP is not fully completed at the time the Plan files its response, the Plan was to submit the reason and timeframe that the remaining corrective actions will be submitted to the Department.

The Plan was required to file an undertaking that the processing of POS claims will be returned from Texas to California by July 16, 2007, and performed by Plan employees.

The Plan was required to file an undertaking that it will employ sufficient staff in California to correct the deficiencies cited in this report, as well as other deficiencies found by the Plan, and to ensure that the Plan maintains compliance with the Knox-Keene Act and Title 28 Regulations at all times.

The Plan was required to file an undertaking that reflected a commitment by its Ultimate Parent Company that the Plan shall have all resources needed (including staffing, information technology systems and funding) to correct the deficiencies cited in this report and to ensure compliance with the Knox-Keene Act and Title 28 Regulations at all times.

As part of the CAP, the Plan will need to file revised administrative services agreements that it has with PHPA, its affiliated or non-affiliated entities to reflect changes in its operations and appropriate access to all, staffing, resources including information technology resources as needed to result in effective compliance with the Knox-Keene Act and Regulations.

The revised agreement(s) were to be filed electronically as amendment filings with the Department.

The Plan's August 30, 2007 response is summarized below:

The Plan stated that it is committed to correcting the deficiencies cited in this report, and to having sufficient staff to maintain and monitor compliance with the Corrective Action Plans submitted with the response and being developed for inclusion in monthly reporting to the Department. The Plan's corrective actions include:

- *Creation of a Vice President of Transactions Oversight position for the Cypress, CA location. In its November 2007 monthly status report to the Department, the Plan reported that a Vice President was hired.*

- *Addition of 24 employees for POS claims processing and data entry, 21 in Cypress, California, and three in San Antonio, Texas.*
- *Addition of ten positions to perform functions related to provider dispute resolution.*
- *Addition of three positions to perform functions related to resolution of member and provider claims issues.*
- *Execution of Undertakings related to administrative capacity. These Undertakings were submitted with the Plan's response.*

Vendor Oversight will include the following:

Lason Systems, Inc.

Lason scans all original documents, keying claims for batch processing into NICE. The following corrective actions have been implemented:

- *On February 19, 2007, the Plan implemented a reporting process that compares Cypress mail room envelopes received to quantities received by Lason. The Program Manager responsible for oversight of the Lason vendor arrangement reviews these daily reports.*
- *The policy related to mail intake and routing will be reviewed and updated by October 1, 2007.*
- *The policy related to DOC DNA correspondence routing will be reviewed and updated by November 30, 2007,*

PacifiCare International Limited

The Plan acknowledged that the transition of its POS claims to Ireland (PacifiCare International Limited (PIL)) was not effective. The Plan confirmed that all POS claims processing, both in and out of network, will be completed in Cypress, California.

The Plan stated that it is not aware of any other Department findings that relate to the use of PIL. The Plan initiated its contractual arrangements with PIL in 1999 to increase its claims processing capabilities.

PacifiCare Health Plan Administrators, Inc. – PSO TX
The Plan confirmed that all POS claims processing, both in and out of network, will be completed in Cypress, CA. The Plan will review other functions performed for the Plan by PHPA – PSO TX and determine if additional controls and/or oversight are necessary to assure the Plan's compliant operations.

MedPlans Partners, Inc.
The Plan also stated that by November 1, 2007, the Plan will no longer use MedPlan Partners, Inc. to process POS out-of-network claims; these claims will have been transitioned to Cypress, CA based staff.

Contract Documentation

The Plan agrees 13 contracts were not provided to the Department in a timely manner. The Plan reminded the Department that the personnel accountable for contract storage moved offices the day of the request. The delay in contract production was impacted by the time required to reconnect computers to networks.

The Plan agreed that 3 contracts were never provided to the Department. The Plan has asked each of these three providers for a copy.

PPO Contract Loading Timeliness and POS Claims Payment Accuracy

The Plan acknowledged that Preferred Provider Organization contracts were negotiated with effective dates that were prior to contract execution and contract load dates, to bridge network gaps for UnitedHealth Group members. The Plan acknowledged that it is possible that POS members could have accessed a newly contracted PPO provider and received services during a time when the contract had not been loaded. However, the Plan is unaware of any Department findings that claims were paid untimely because of delays in contract loading. The Plan stated that it would respond to additional issues identified by the Department in its Preliminary Report.

Document Routing

The Plan stated that its correspondence is routed to 21 different queues related to the Plan's commercial products, based on subject matter. The queues are reviewed on a daily basis to match to claims, update provider demographic information, initiate a member appeal, etc. The following corrective actions have been implemented for correspondence:

- *The 21 correspondence queues have been defined and are maintained separately to ease review and routing.*
- *Owners and back up owners for each queue have been identified.*
- *Weekly correspondence inventory and aging reports for each queue were written by April 2007.*
- *Beginning July 11, 2007, employees assigned to each queue and the Transaction Project Director meet weekly to review progress and inventory levels to monitor inventory levels and ensure appropriate turn around time.*

The Plan responded that Management Oversight will include the Plan's President, Chief Financial Officer, Vice President of Transactions Oversight and Medical Director.

The Plan stated that its President, Chief Financial Officer and Medical Director have been and continue to be located in Cypress, CA in addition to Vice President of Transactions Oversight position, which is newly created to enhance Plan oversight. The Plan has retained adequate oversight, authority and responsibility through the management team listed above as well as other Plan staff.

The Plan considers these positions to be employees of the Plan. The salary cost of these positions is included in the Plan's statutory financial statements. The Plan does not consider the payroll tax identification number relevant to the substance of each person's commitment of time and effort to the Plan. This issue has been documented fully with the Department.

POS Claims Processing Undertaking

The Plan's undertaking related to POS claims processing was included in its response.

Sufficient Staffing

The Plan's undertaking related to Sufficient Staffing was included in its response.

Ultimate Parent Resource Commitment Undertaking

The Plan's undertaking related to the Ultimate Parent commitment that the Plan shall have all resources needed (including staffing, information technology systems and funding) to correct deficiencies cited in this report to ensure compliance with the Knox-Keene Act and Title 28 Regulations at all times was included in the Plan's response.

The Executive Vice President, UnitedHealth Group, affirmed the Ultimate Parent Company's commitment to PacifiCare to have the resources necessary to comply with the Knox-Keene Act and Title 28 Regulations and the California market at a meeting with Cindy Ehnes and members of the DMHC management staff on July 9, 2007. UnitedHealth Group and the Plan believe that local accountability remains a significant force in the relationship between consumers and their health plans

Revised Administrative Services Agreements

On June 19, 2007, the Plan submitted an amendment to its Administrative and Solicitor Firm Services Agreement with PHPA pursuant to Undertaking No. 4 of the Plan's Material Modification filing, Transition of Routine Plan Functions, DMHC Reference No. 20060700. The Plan has revised the June 19th Amendment to reflect changes in its operations and appropriate access to staffing and other resources, including information technology resources, as needed to result in effective compliance with the Knox-Keene Act and Regulations (the "Revised Amendment"). The Revised Amendment was eFiled with the Department on August 30, 2007. A copy of the Revised Amendment was included in the Plan's response.

The following are additional administrative findings not reported in the Preliminary Interim Report but were reported in the Preliminary Report:

- The Plan indicated that it follows contract loading timeframes established in policies of its Parent company. During discussions with the Plan's provider dispute unit and its network management unit, the Plan indicated that "rework" projects containing claims

that require reprocessing due to retroactive contract provisions are generally initiated by network management. However, the Parent company's procedures do not specifically state the process for routinely identifying those claims that fall within the retro contract period and for reprocessing the impacted claims.

- The Plan acknowledged that comments documenting the loading of a contract into the contract information system are "overridden" whenever a change is made. This results in a lack of an audit trail to document the dates when new or revised contract provisions are loaded into the system.

- While the Plan acknowledged that Preferred Provider Organization contracts were negotiated with effective dates prior to contract execution and contract load dates, to bridge network gaps for UnitedHealth Group members, the Plan stated in its August 30, 2007 response that it was unaware of any Department findings indicating that claims were paid untimely due to delays in the contract loading. Subsequent to this date, the Department brought to the Plan's attention rework project #58048 which documented that a United "gap" contract was signed on June 26, 2006 but was not loaded into the Plan's contract database until October 6, 2006. The project contained claims with dates of service that were within the effective dates of the contract but due to the delay in loading the contract, the correct payment of the claims were delayed. Additionally, the Department requested the Plan to review thirty-five (35) contracts that were loaded late to determine if claims were potentially impacted and should be reprocessed. Of that sample, sixteen (16), or 45.7 %, were potentially impacted. However the Plan did not identify these claims to be reprocessed. The following are examples:

Contract No.	Contract Load Days Lapsed after Signed by Provider	Plan Comments
308004	276 days	Rate changed. Potential impact to drug claims, but reprocessing was not initiated.
313667	221 days	Potential claims impacted, but reprocessing was not initiated.
317604	128 days	Potential claims impacted, but reprocessing was not initiated.
326942	534 days	Potential claims impacted, but reprocessing was not initiated.
322194	366 days	Incorrect effective date entered. Potential claims impacted, but reprocessing was not initiated.

All of the above issues were referred to the Office of Enforcement for administrative action.

The Plan was required to submit a revised CAP that includes revisions to its operations and policies and procedures that will include, but are not limited, to correction of the deficiencies

noted above. The policies and procedures were to include procedures that reflect that the Plan is routinely monitoring retroactive contract activity, as well as, procedures to review and identify all affected claims including those that have been submitted as provider disputes or projects requiring reprocessing as a result of the retroactive contract provisions. The policies and procedures were also to reflect routine procedures to identify and review all contracts loaded late or outside of the established timeframes indicated by the contract loading guidelines. The CAP was to state the types of reports that will be maintained by the Plan to document the loading of the contracts and the Plan's oversight of this process.

In addition the Plan was required to review all provider contracts in the NICE and RIMS claims systems with retroactive effective dates or late load dates for the period January 1, 2006 through the date of the Plan's response to this report. The Plan was required to identify all potential claims that were impacted by the retroactive contract provisions. The Plan was required to submit a spreadsheet of all claims requiring remediation as a result of the retroactive contract provisions. The spreadsheet was to include the following fields:

- Contract number
- Provider name
- Signature dates
- Contract load dates
- Reprocessed claims by claim number
- Date original claim received
- Date original claim paid
- Additional information received, if applicable
- Additional payment amount made
- Date additional payment made
- Interest and penalties paid
- Check number for additional payment made

If the Plan was unable to complete remediation by the due date of the response to the Preliminary Report, the Plan was required to submit a timeline that is no longer than one year from the due date which reflects progress and completion of the remediation. In addition, the Plan shall submit monthly status reports to the Department until the remediation is completed.

The Plan's November 14, 2007 response is summarized below:

The Plan acknowledged the Department's findings. The Plan stated that by January 1, 2008, the Plan will implement a revised process and related Policy and procedure document to automatically refer, on a regular basis, all retro active contract loads to the claim project review team to review and remediate impacted claims.

The Plan stated it will identify all potential claims that were impacted by a retroactive effective contract during the period January 1, 2006 through November 14, 2007 to determine that the

correct contract rate was used. The Plan is in the process of performing a quality review of the report detailing the providers to be reviewed for possible remediation to ensure its accuracy. The Plan estimates completion of the quality review by December 14, 2007. After the quality review is complete, the Plan will determine the remediation timing and will provide updates to that work plan in the monthly reporting to the Department.

The Department acknowledges that the Plan was to implement a revised process and related policy and procedure document by January 1, 2008. The Plan needs to provide a description of the revised process and a copy of the related policy and procedure document with its response to this Final Report. In addition, these revised policy and procedure document should address the loading of a contract so that there is an audit trail of the date(s) when new or revised contract provisions are loaded into the system.

The Department acknowledges that the Plan anticipates that its remediation efforts will be completed by August 2008 as reported in its November 2007 status report. In addition, the Department acknowledges that 95% compliance may not be achieved by the Plan until remediation is complete because of the remediation's impact on the compliance percentage. However, the Plan is required to submit evidence of its remediation efforts on a monthly basis. These monthly status reports are due within 15 days following the close of each month. The first status report will be due on February 15, 2008, listing individually by claim all interest and penalties paid up to January 31, 2008. The status report should be submitted through the Department's eFiling web portal, as described in the cover letter, until the remediation is fully completed. Large remediation files can be submitted directly to the Department on a CD with an E-1 filing submitted through the web portal stating that the remediation file was submitted directly to the Department on a CD.

SECTION II. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

No response was required for this section.

PacifiCare®

A UnitedHealthcare Company

January 25, 2008

Ms. Janet Nozaki
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight
Department of Managed Health Care
320 West Fourth Street, Suite 880
Los Angeles, California 90013

RE: FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF PACIFICARE OF CALIFORNIA

Dear Ms. Nozaki:

PacifiCare of California ("PacifiCare" or the "Plan") appreciates the opportunity to respond to the Department of Managed Health Care ("Department") Final Report of the Non-Routine Examination dated January 16, 2008. The Plan respectfully submits the following addendum response to the Plan's August 30, 2007 and November 14, 2007 responses to the report within the required 10-day timeframe.

PacifiCare affirms that the non-routine exam, which commenced on June 4, 2007, resulted from PacifiCare's self-reporting of processing errors related to Point of Service ("POS") Out-of-Network ("OON") claims. The Plan is working collaboratively with the Department to resolve these issues and others identified by the Department. The Plan is committed to correcting the deficiencies and to maintaining appropriate administrative capacity to effectively perform the Plan's duties on behalf of enrollees and health care providers, in compliance with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended, and its related regulations (the "Knox-Keene Requirements"). The Plan's Chief Financial Officer requested that the Department release a Preliminary Interim Report in July 2007 prior to the completion of the examination to ensure that the Plan's corrective actions complied with the Department's expectations.

This letter describes PacifiCare's good faith and diligent efforts to remediate the deficiencies. As indicated in the Plan's responses to the Department's Preliminary Reports, PacifiCare has taken significant steps to achieve and sustain compliant operations. As previously reported to the Department, PacifiCare has:

- Self-reported processing errors related to its POS OON claims to the Department which were caused by OON POS claims not being entered into the RIMS claims processing engine which accesses PPO contracts for OON benefits.

- Created and filled the Vice President of Transactions Oversight position in Cypress, California to monitor claims processing and Provider Dispute Resolution.
- Implemented new procedures to ensure that POS OON claims were not denied inappropriately as duplicates in July 2007.
- Hired 48 full time staff and created 10 new positions to perform POS claims processing, Provider Dispute Resolution, and functions related to provider claims issue resolution.
- Provided monthly reports to the Department beginning in October 2007, for the month ending September 30, 2007, and will continue to provide such reports through June 30, 2008 or later, if appropriate. The Plan's Chief Financial Officer reviews these reports with the Division of Financial Oversight. The reports include detailed corrective actions and progress on POS claims processing, late paid claims interest and penalty, provider dispute resolution, misdirected claims, and rework for claims impacted by retroactive contract terms.
- Initiated weekly claims audits by internal staff dedicated to quality oversight of operations; this team is independent of the claims processing team and reports to a different management team within UnitedHealthcare.
- Submitted an undertaking setting forth the commitment of UnitedHealth Group that the Plan shall have all resources needed (including staffing, information technology systems and funding) to correct deficiencies to ensure compliance with the Knox-Keene Requirements.

Claims Settlement Practices

Point of Service Claims: PacifiCare initiated implementation of corrective actions to address noncompliance with POS claims processing when it self-reported this issue in February 2007. PacifiCare has added 24 employees for POS claims processing and data entry and centralized this function in Cypress, California. POS claims processing turnaround times and accuracy have improved significantly, as reported monthly to the Department (most recently on January 8, 2008).

The Plan believes that the amount of inappropriate POS duplicate denials noted by the Department during the non-routine examination was caused by the POS corrective action plan; this will not be a recurring issue. A three month audit of POS OON denials indicates no further duplicate denials.

It is important to note that PacifiCare's commercial membership consists of 1,243,999 members, of which 56,017, or 4.5%, are enrolled in its POS plans as reported in the Quarterly Financial Reporting Form submitted to the Department on November 14, 2007. Consequently, the OON POS claims processing findings are not applicable to the vast majority of PacifiCare's HMO members, who typically receive care from the capitated, delegated network model.

HMO Denied Claims – Misdirected: The Plan has added six additional staff to research the root cause of the inappropriate denials on NICE due to incorrect determination of financial responsibility. The Plan has also identified those claims that were processed incorrectly from February 9, 2007 to May 31, 2007 because the out of area determination system programming

was inaccurate. The Plan discussed the comprehensive reprocessing plan and related timing with the Department on January 8, 2008.

Late Paid Claims: The Plan has audited late paid claims for HMO claims on the NICE system and POS OON claims on the RIMS system to determine root causes for late paid claims and inaccuracy of interest payments for late paid claims. The Plan has responded to results of these audits by re-training claims processing staff on accurate interest rates for late payment and appropriate application of the penalty. The Plan will continue to conduct focused audits on late paid claims interest and penalties through March 31, 2008 or later if the issues have not been resolved; these audits indicate improvement on underpaid interest. The audit results through November 2007 were review with the Department on January 8, 2008.

Provider Dispute Resolution Mechanism

PacifiCare has conducted a comprehensive self-audit of the provider dispute resolution ("PDR") process to identify root cause of inaccurate and/or late PDR determinations and to determine necessary improvements, as presented in its monthly report. New procedures have been implemented to distinguish PDR from all other inquiries. The Plan has hired 18 additional employees to perform functions related to PDR and provider claims issue resolution. The Plan is carefully monitoring timely issuance of PDR acknowledgement letters, late determinations, and inventory management through enhanced reporting to Plan management. The PDR staff and claims processing staff dedicated to supporting PDR have begun holding weekly meetings to ensure accurate and timely effectuations of PDR determinations and timely payment upon resolution of the dispute, when appropriate, to providers.

PacifiCare has completed its implementation of the corrective action regarding resolution of PDR questions by Customer Service. In December 2007, the Customer Service team was retrained on handling PDR inquiries to stress the importance of reviewing not only the claims engines for PDR status but also REVA, the claims inquiry tracking tool, which identifies received, pending and closed claims inquiries, including PDRs.

PacifiCare acknowledges that its PDR tracking system, REVA, requires enhancements to function more efficiently and effectively to help improve the timeliness of the acknowledgement letter and determination letter processes. As discussed with the Department on January 8, 2008, certain technology enhancements to REVA are completed and others are in progress and on track to be completed by March 31, 2008. PacifiCare shares the Department's commitment to a transparent and fully compliant PDR system.

Administrative Capacity

PacifiCare concurs that additional oversight of claims processing functions to affiliated and non-affiliated entities is necessary to ensure compliance with state laws and regulations. Consequently, PacifiCare created the Vice President of Transactions Oversight position to monitor compliance of these claims processing functions as well as the functions retained in Cypress, e.g., PDR processing.

PacifiCare has hired 48 additional staff to perform POS claims processing, Provider Dispute Resolution, and functions related to member and provider claims issue resolution and has created 10 positions to perform these activities. PacifiCare believes that the additional staff as well as centralizing the POS claims processing function in one location (Cypress) will enhance its administrative capacity.

UnitedHealth Group, the Plan's ultimate parent, has signed an Undertaking specifying that the Plan shall have all resources needed (including staffing, information technology systems and funding) to correct deficiencies cited in the non-routine audit report to ensure compliance with the Knox-Keene Requirements.

The Plan wishes to clarify that the provider contract loading issues experienced in 2006 were directly applicable to the PPO networks of the Plan's affiliates, PacifiCare Life and Health Insurance Company and United HealthCare Insurance Company, rather than the Plan. The contract loading issues affected the POS OON claims processing. However, the staff dedicated to addressing PPO provider contract loading issues is not the staff responsible for POS claims processing; the POS claims processing staff were not re-directed to contract loading responsibilities. Therefore, this is not reflective of Plan administrative capacity issues. Corrective actions include development of a Policy and Procedure to automatically refer, on a regular basis, all retroactive contract loads to the claim project review team to review and remediate impacted claims. Pursuant to the Department's request, the Plan is researching retroactive HMO contracts to determine if system changes are necessary.

In each of three monthly reports presented to the Department, the Plan has demonstrated significant improvement in the total inventory and the aged inventory of documents contained in its document management systems ("DocDNA"). These improved turnaround times will help ensure that documents such as medical records are delivered to the appropriate functional areas for timely processing of claims and provider disputes. In October 2007, a work plan to resolve document management and routing issues was developed by functional managers and the non-affiliated entity; a service level agreement to monitor the vendor's performance has also been created. The Correspondence Routing Policy related to DocDNA, has been completed and identified changes are in the process of being implemented.

PacifiCare acknowledges that the Final Report identifies additional reporting and will submit this information separately within the required timeframes.

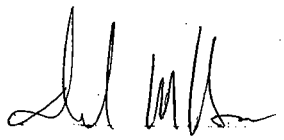
Conclusion

The Plan is working collaboratively with the Department to resolve the issues identified by the Department and is committed to having appropriate administrative capacity to effectively perform the Plan's duties on behalf of enrollees and health care providers, in compliance with Knox-Keene Requirements. PacifiCare initiated implementation of corrective actions to address noncompliance with POS claims processing when it self-reported this issue in February 2007. PacifiCare has achieved significant improvement in POS OON claims processing and is implementing corrective actions to resolve findings related to other claims processing issues and PDR issues. The Plan has enhanced its administrative capacity by establishing the Vice

President of Transactions Oversight position in Cypress to monitor compliance of the claim functions as well as functions retained in Cypress, e.g., PDR processing, and by hiring additional staff to perform POS claims processing, Provider Dispute Resolution, and functions related to member and provider claims issue resolution.

The Plan respectfully submits that the significant corrective action steps described in this letter reflect the dedication of the Plan and UnitedHealth Group to achieve and maintain compliance with the Knox-Keene requirements.

Sincerely,



David Hansen
President and Chief Executive Officer

cc: Susan Berkel, Chief Financial Officer
Joy Higa, Vice President
Nancy Monk, Vice President